Origination:	*8/18/2016*
Last Approved:	*2/9/2018*
Last Revised:	*1/17/2018*
Next Review:	*2/8/2021*
Owner:	*Valerie Holt*
Policy Area:	*Ambulatory Care Policy Manual*
References:	
Applicability:	*University of Rochester - Strong Memorial Hospital*

0.3.4 Use of Medical Scribes Policy

	AMBULATORY CARE MANUAL	
UR MEDICINE	Section 0: Access Policies 0.3.0 Improve Communications with Referring Providers and Patients	Date:8/18/16
	0.3.4 Use of Medical Scribes	
POLICY		

Purpose: To provide direction to attending physicians regarding use of medical scribes in patient care areas.

Policy	Goal	Metric Measurement
Medical Scribes: Scribes are unlicensed staff hired to enter patient information into the EMR at the direction of the attending physician. • UR Med contracts for medical scribes through ScribeAmerica. • Scribes must be fully credentialed through ScribeAmerica. • Scribes are trained in the process of scribing through ScribeAmerica. • Scribes' performance evaluations are completed by ScribeAmerica with feedback from providers. • Scribes must complete an employee Health Update. • Scribes must sign off on University forms prior to any contact with patients.	Comply with standards; assure medical scribes are on-boarded in a standard manner.	Review of Medical Scribe personnel files for completion of all requirements at hire.
NOTE: Any exceptions to use of ScribeAmerica staff must have written approval of URMFG COO. • Scribes conform to all requirements of contract employees for UR Med and TJC. • Scribes adhere to the UR Med job description. • Scribes use a specific profile in eRecord and must use his/her own password to document in eRecord. • Scribes capture accurate documentation of the clinical	Conform to eRecord use standards for Medical Scribes.	Periodic compliance audits.

encounter in eRecord at the time of the encounter and at the direction of the physician. • Scribes must complete the approved scribing attestation. "I _____, am scribing for and in the presence of Dr._____." • Scribes must electronically sign and date the note/ attestation. Medical Scribes **Can:** • Assist the provider in navigating the EMR; • Locate prior notes, labs, imaging for provider review; • Enter documentation into eRecord on direction of the provider. • Enter or pend orders in eRecord, with the following exceptions: ◦ Medication orders that are new, involve complex dose/ frequency changes, or are complex (e.g., chemotherapy, biologicals). ◦ Advanced imaging orders (e.g., CT, MRI, PET) ◦ Interventional procedures ◦ Nuclear medicine studies ◦ Imaging stress tests Scribes become most efficient working with a provider when the provider has a minimum of 2 clinic sessions per week. Medical Scribes **Cannot:** • Take verbal orders; • Translate for patients; • Handle bodily fluids; • Touch patients; • Act independently without direct clinical oversight; • Conduct other duties while acting as the medical scribe; • Be the final author/signature on notes. **NOTE:** Patient has the right to refuse to have a scribe present. **Attending Physician**: Only attending Physicians can be assigned medical scribes. Directs the scribe in capture of documentation in eRecord. Is responsible for all documentation and must verify and attest that the note reflects the services provided. Provider must personally add the attestation to the note of the scribe. "I, Dr. _____, personally performed the services described in this documentation, as scribed by _____ in my presence, and it is accurate and complete."	Provider is responsible for all documentation in the patient record by the Medical Scribe. Department will be able to document that key criteria have been achieved through use of the scribe. Cost of scribe, laptop and parking (unless no cost for parking) is a departmental responsibility.	Periodic compliance audits. Review of monthly data in McKesson dashboard.

Is accountable for compliance with this policy. **Approval of Scribes for Attending Providers** Business Improvement Plan, approved by the Department Chair, must be submitted to the URMFG COO/ CFO, or to SMH COO/ CFO if for an SMH practice, and includes metrics that address the need to: • Improve access to a provider by creating greater provider efficiency; • Support high volume providers; • Increase the volume of patients per week for the provider; • Improve documentation; • Improve closure of records within 72 hours; • Improve referring provider satisfaction with information received; • Improve quality of work life for the provider; • Improve provider use of the EMR. Provider/ Division or Department is responsible for the cost of medical scribes.		

Reviewed:URMFG Clinical Operations Committee: 8/18/16, Addendum 12/20/17

URMFG Executive Committee: 8/24/16, Addendum 1/10/18

Attachments:

image1.png

Approval Signatures

Approver	Date
Valerie Holt	2/9/2018